Family Care UPDATE

Options for Long Term Care | Volume 1, March 2001

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Increase consumer choice

Improve access to services

Create a comprehensive and flexible long term care service system

Improve quality through a focus on health and social outcomes

Create a cost effective long-term care system for the future

FAMILY CARE
Options for Long-Term Care

From the Desk of…

Chuck Wilhelm, Director, Office of Strategic Finance

It has been a busy and rewarding year. It is hard to believe the first anniversary of Family Care CMO operations has passed. CMOs have more than 2,500 members and we continue to hear stories of creative solutions to care management challenges that are possible because of the flexibility of the Family Care benefit.

Resource Centers are busier than anyone expected. The marketing efforts of the Resource Centers have proven to be extremely successful. In fact, some of the Resource Centers are working together to create informational videos to air on local television stations. Resource Center staff have found themselves inundated with requests for information and assistance, as well as referrals from residential facilities for pre-admission consultation. Staff are busier than ever completing functional screens, offering assistance with financial declarations, and providing long term care options counseling.

Richland County began Resource Center operations on November 1, 2000 and CMO operations on January 1, 2001. Some 130 members were enrolled into the CMO immediately. Many will be watching Richland County's efforts closely because it is representative of the many small, rural counties around Wisconsin. We congratulate them for taking on this challenge and wish them great success.

Articles elsewhere in this newsletter describe some of the quality assurance efforts that are underway. Member interviews will allow us to measure whether outcomes have actually been achieved for members. The Department and the pilots are learning what is working and what needs improvement, and continual improvement will be our goal throughout this pilot phase.

To quote Ann Koehler, care manager from Fond du Lac, "We should keep building on what is working. It's nice to stop and reflect on all that we have accomplished but we can't stand still for too long - we have to keep moving ahead!" ◆

Wisconsin Council on Long Term Care Meets with Governor Thompson's Staff

The Council on Long Term Care met on December 1st with staff from Governor Tommy Thompson's Office and the Department of Administration to share with them their budget recommendations regarding Family Care pilots and other long term care programs. The Council was briefed on the projections for future state revenue, which do not look promising. In light of the fiscal realities that the state is facing, the Council recommended key items to the Governor for his consideration, including full funding for the Family Care pilots and for adding additional Community Options Program resources for non-Family Care counties and target populations. In addition, they urged the Governor to proactively

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budget the resources needed to relocate individuals into the community when nursing homes close. Finally, the Council recommended that the Governor continue the Council through the next biennium. Current Family Care law sunsets the Council on June 30, 2001.

The Council is also charged with the responsibility to produce an annual report to the Governor and the Legislature on the achievements and problems in the Family Care program. Tom Rand, Council Chair, appointed two subcommittees to review current data and develop recommendations. Those committees are the Resource Center Subcommittee, chaired by Carol Eschner, and the CMO Subcommittee, chaired by Julie Litza. The subcommittees will be meeting in the next two months to review existing data and develop recommendations for the report. The Council plans to review the subcommittee reports and finalize their recommendations by the end of March, with the Annual Report to be released sometime in May. ◆

Member Outcome Interviews

During the planning of Family Care, a workgroup of consumers and others stakeholders identified 14 personal outcomes that Care Management Organizations (CMOs) will help members achieve. One approach to measuring CMO quality therefore is determining whether consumers achieve the outcomes they expect from the services and supports they receive. To do the best possible job, CMOs must know which of the services and supports they provide lead to the best possible outcomes. Over a ten-week period from the past November through January, 375 CMO members were interviewed about their individual preferences related to the 14 Family Care consumer outcomes. These members' care managers were also interviewed about the options given to consumers, about how the member was provided support while making choices about services, and about whether the CMO was as creative as possible when offering options to help the member achieve the outcomes important to him or her.

Working from a randomly chosen list of CMO members, staff from each CMO contacted members to see if they were willing to participate in the outcome interview. Participation

Over a ten-week period from the past November through January, 375 CMO members were interviewed about their individual preferences.

was voluntary, and about 26% of members contacted declined to participate, citing reasons such as "attending college," "not enough time," "everything is going well," or medical reasons. Members were allowed to end the interview at any point or decline to answer any question, and interviewers paid close attention to members' body language and made adjustments if the member was becoming fatigued. Because the members chose the location of the interview, most occurred at members' homes or their place of employment,

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Family Care Conference Postponed

The Council on Long Term Care had begun planning for a one-day Family Care Conference for mid-May to present their Annual Report and to inform key consumer leaders and others about the current status of Family Care. The conference has now been postponed and will hopefully be rescheduled for a later date.

Family Care Update

Family Care Update is a publication of the Department of Health and Family Services and is issued by staff in the Office of Strategic Finance for counties, advocates, Family Care pilot sites, and other people interested in long term care redesign and Family Care.

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Visit our web site at **www.dhfs.state.wi.us\LTCare** for up-to-date information on Wisconsin's long term care redesign project.

sometimes even at a local restaurant. Interview times were set to be convenient for members, not interfering with the member's own work hours, for instance. On average, interviews lasted just over an hour.

The interview process and decision making about whether outcomes have been met are based on methods developed by The Council on Quality and Leadership. DHFS plans to use these methods to produce valid and reliable measures of individual outcomes; and to shed light on the relationship between outcomes and CMO processes. The interview results have been entered into a secure database, and DHFS is beginning to analyze the information with assistance from The Council on Quality and Leadership.

Once analyzed, this data will be released to CMOs so they can identify and organize staff around members' priority outcomes, strengthen the structures and processes that are associated with achieving outcomes, and be innovative in coordinating services and supports. Over time CMOs can use this data to improve their performance by comparing outcomes with their own baseline, with other CMOs, and with The Council on Quality and Leadership's national database. ◆

Check our web site for the latest news

www.dhfs.state.wi.us/LTCare

Best Practice Ideas

from the Family Care CMOs

One result of quality site visits made to each of the Family Care Care Management Organizations (CMOs) during the past five months was the identification of particular strengths in each program. These unique strengths can serve as "best practice" approaches to ensuring quality for consumers.

The **La Crosse County** CMO establishes priorities for its quality assurance/quality improvement program from the members' point of view – not just from the administration's. Plans for involving members in the quality program includes a member satisfaction survey, with members who serve on the Quality Assurance/Quality Improvement Committee helping to develop survey questions, doing phone interviews with members, and analyzing results of the survey. Members also participate in determining the focus area for the CMO's Performance Improvement Project.

The **Milwaukee County** CMO is building processes that blend the nurse and social worker roles by completing comprehensive assessments together, developing 'tickler' systems to share important member health information with each other on a daily basis, and making efforts toward development of prevention/wellness programs for members. Nurses are active members of the interdisciplinary teams, and establish linkages with the member's primary care physician. The nurses coordinate medications and treatments with the primary care physician and any specialist physicians involved. Nurse administrators have developed protocols for health and safety in CBRFs and have established linkages with hospital discharge planners. The interdisciplinary teams have found that health issues for members are better managed when both the social worker and nurse are working as a coordinated team with the member. Social workers often have more frequent contact with members, so that providing them with individual member's health information and 'protocols' to follow helps identify problems in their early stages and avoid health crises.

Community Care of Portage County has developed a strong internal member advocate program. This staff person contacts each member two to three months after enrollment to answer any questions, and to make sure the member understands the Member Handbook and how to interact with the interdisciplinary team. During this contact the internal advocate also receives feedback on quality of services and other issues from the member. This practice offers members easy access to the CMO staff person charged with assisting members with any problems, and offers an additional resource beyond the interdisciplinary team and Family Care Independent Advocate for problem solving, planning and negotiating if disagreements arise between the member and providers.

At **Creative Care Options of Fond du Lac County**, interdisciplinary teams are organized so that staff with experience in developmental disabilities, physical disabilities, and elderly services all work together. The interdisciplinary team members thus learn from each other's experiences and challenge each other to think differently about the possibilities for creative supports for people in the community. The interdisciplinary teams also have a paraprofessional member who helps with paperwork and routine communications, so that the RNs and social workers can focus on quality case management. ◆

What happens to a resident when his nursing home closes? A Case Study of Family Care Success

Mr. Eugene Bingenheimer, aged 68, says that his "life began at the age of 63." This is his story as told by his Care Manager, Ruth Ryshke R.N.

Former Governor Thompson, Mr. Bingenheirmer, and his case manager, Ruth Ryske before the Governor's final State of the State Address on January 31, 2001. The Governor acknowledged Mr. Bingenheimer in his address as a shining Family Care success story.

Eugene Bingenheimer had been a resident of the Marina View Nursing Facility in Milwaukee for four years when it was announced it would be closing at the end of 2000. One might have assumed that Mr. Bingenheimer would relocate to another nursing home but a surprising turn of events took place. Eugene was referred to the Milwaukee Department on Aging Resource Center for assistance.

Eugene worked driving a forklift at a canning factory for 14 years. During his young adult years, he lived with his parents and did little socializing--the noise and stress of his job sent him home each day at lunch and immediately after work. In 1964 he suffered a nervous collapse and was not able to return to his job. Eugene describes himself during those years as "being a spectator, but never able to participate" in life. His conditions included depression, anxiety disorder and also some physical problems including hypertension. For the next 31 years his mental and physical condition slowly deteriorated, and treatments for these conditions met with little success. By 1995 he was unable to care for himself and moved to the nursing facility. During his stay there, he began to respond to treatment and slowly regained his sense of self.

Shortly after the Marina View closing was announced in September 2000, Eugene met with Resource Center staff who believed he could flourish outside the nursing home setting. He enrolled in the Family Care CMO and met with his new Family Care interdisciplinary team, including R.N. Ruth Ryshke. Eugene and Ruth discussed his past and current situation and a case plan was developed that would meet Eugene's needs while taking into account what he wanted for himself.

According to Ruth, Eugene felt that the time he lived in the nursing home had been the best years of his life because the staff had encouraged him to get involved in activities and helped him to develop social skills. He felt that loving, caring people had surrounded him there. However, he agreed that he no longer needed the skilled level of care provided in a nursing home environment. On September 25 he told Ms. Ryshke that he felt he could leave the nursing home but that he would like to stay in the same east side neighborhood because the view of the lake made him happy and calm, and that he preferred to live with a group of people instead of living alone in an apartment.

A few days later he toured Chai Point, a community based residential facility that provides independent living in a group setting. It is located near the nursing home and also overlooks the lake. Eugene knew immediately this was the place for him.

Mr. Bingenheimer is able to live at Chai Point because the Family Care benefit provided him with a care management team who developed and periodically reviews his care plan with him. The team R.N. also provides coordination with his doctors so that his medical and psychiatric care is coordinated. Family Care funding also allows Eugene to receive a comprehensive range of services tailored to meet his individual needs. His benefits include placement in the community based residential facility, disposable medical supplies and equipment, and monthly visits by a home care nurse.

The story of Mr. Bingenheimer is the story of everything that is good about Family Care. There is no lengthy waiting period for services. Clients are consulted and become part of their personal care management team. Funding for services is essentially immediate and waiting lists

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should soon be a thing of the past. Most importantly, Family Care members like Mr. Bingenheimer have a choice about how they want to live their lives.

Eugene moved to Chai Point on October 15, 2000, less than 30 days after his initial meeting with the interdisciplinary team. He describes his new home as a "vacation resort" and says, "I can't believe this happened to me. I was told that the nursing home would close around Christmas time and I was going to be all alone during the Holidays. Now I am surrounded with so many friends, wonderful activities, a great view and I can still walk right down the street and visit my friends that are still in the nursing home. This is too good to be true." ◆

--Editor's Note: Mr. Bingenheimer accepted a position as a consumer member of Milwaukee's CMO governing board. The editor and FC Update staff would like to thank Eugene Bingenheimer and Milwaukee County Department of Aging staff, including Linda Cieslik, Meg Gleeson, Chris Hess, and Ruth Ryshke for contributing this story to the FC Update.

Did You Know?

Findings from the Aging and Disability Resource Center Pilots:

From July to December of 2000, 34,450 contacts for information and assistance were made to Family Care Resource Centers. More than 8,500 were requests for information about how to meet basic needs and locate financial resources. 1,623 individuals required short term services to help them avoid a potential crisis situation.

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Approximately 90% of Long Term Care Functional Screens completed result in a comprehensive level of care, 8% result in intermediate level of care, and 2% in no level of care.

Who 'ya gonna call?

A Local Aging and Disability Resource Center, Of Course!

Fond du Lac County
Toll Free: 1-888-435-7335
Phone: 920-929-3466
www.execpc.com/~jev/services.html

Jackson County
Toll Free: 1-877-441-0915
Phone: 715-284-5898
TTY: 715-284-8941

Kenosha County
Aging & Disability Resource Center
Toll Free: 1-800-472-8008*
Phone: 262-605-6646
TTY: 262-605-6663
www.co.kenosha.wi.us/ADRC/index.html

Developmental Disabilities
Resource Center
Phone: 262-653-3880

* for Kenosha County residents only

La Crosse County
Toll Free: 1-800-500-3910
Phone: 608-785-5700

Marathon County
Toll Free 1-888-486-9545
Phone 715-261-6070
www.adrc.co.marathon.wi.us

Milwaukee County
Phone: 414-289-6874
www.milwaukeecounty.com

Portage County
Toll Free: 1-800-586-5055
Phone: 715-346-1405
www.co.portage.wi.us/Aging

Richland County
Phone: 608-647-4616

Trempealeau County
Toll Free: 1-800-273-2001
Phone: 715-538-2001
TDD: 715-538-2737

Status of Family Care Pilots

By mid-February, 2,543 people* had enrolled in Family Care (approximately 56% of the people enrolled are elderly. The remainder are people with disabilities.) The chart below provides a brief status report on each pilot county.

Pilot County	Resource Center (RC) Status as of February 2001	CMO Status as of February 2001*
Fond du Lac	Began operating early 1998.	Began enrollment in February 2000. Approx. 598 enrollees as of 2-01.
Portage	Began operating early 1998.	Began enrollment in April 2000. Approx. 358 enrollees as of 2-01.
La Crosse	Began operating early 1998.	Began enrollment in April 2000. Approx. 707 enrollees as of 2-01.
Milwaukee	Began operating early 1998.	Began enrollment in July 2000. Approx. 746 enrollees as of 2-01.
Richland	Began operating November 2000.	Began enrollment in January 2001. Approx. 134 enrollees as of 2-01.
Kenosha	Began operating early 1998. Kenosha County has two RCs--one for aging and physically disabled and one for developmentally disabled.	Plan to start enrollment in 2002.
Marathon	Began operating early 1998.	Plan to start enrollment in 2003.
Jackson	Began operating early 1998.	Not a CMO pilot (didn't apply).
Trempeleau	Began operating early 1998.	Not a CMO pilot (didn't apply).
Forest, Vilas, Oneida	Plan to start operations in 2002.	Plan to start enrollment in 2003. Will serve people with developmental disabilities only.

** As of 2/15/01. Data from State MMIS System.*

Interdisciplinary Teams After One Year: Nurses and Social Workers in Fond du Lac County

An interdisciplinary team at work. From left to right: Ardis Kietzman, member; Ann Koehler, Social Worker; and Debra Kurek, RN.

The first Care Management Organization (CMO) to offer the Family Care benefit was Creative Care Options of Fond du Lac County, which began serving members on February 1, 2000. Ann Koehler and Deb Kurek have been members of the interdisciplinary team there since the CMO's inception. Ann is a social worker who works primarily with frail elders and people with physical disabilities. Deb is a registered nurse who works with frail elders, people with physical disabilities and people with developmental disabilities. Ann and Deb shared their experiences working as members of an interdisciplinary team over the past 12 months.

"Care managers are working with people on a very personal level," Ann said. "Family Care encourages consumers to be very involved in the decision making process. They share responsibility for development of their care plans, which means care mangers don't have an authority role even though they help make decisions about what services the CMO will provide." In Ann's experience, this has resulted in better quality for consumers. "We can offer very individualized services to frail elders who want to remain in their homes. There is a great deal of flexibility in determining what services to provide, and this allows creative support options for people." Deb agreed, saying that, "the Family Care decision-making process results in both staff and consumers being better informed and confident with their decisions."

Interdisciplinary teams include the consumer and, at a minimum, a nurse and a social worker. Deb feels having an interdisciplinary team involved with the member is an improvement over the previous system. "Being a part of an interdisciplinary team broadens your viewpoint as a nurse to more than just medical issues because you're working with the social worker on a daily basis. You can be more holistic and consider how disabilities and other issues impact overall health and quality of life." When asked if there was ever confusion about who is in charge when a nurse and social worker are on the same team, Deb replied, "We go back and forth. The social worker often takes the primary case manager role. When health issues are a priority, the nurse can take the lead. We hand off primary and back-up roles depending on the needs of the consumer."

Ann says that the open sharing of information between the nurse and social worker and the opportunity to benefit from each other's expertise is an invaluable resource. "Previously, there were a lot of barriers for case managers and nurses to work as a team. Removing these barriers has made it possible for consumers to have better experiences. In the old system consumers had to go through social workers to get to the nurse. Now they just call the nurse and health care issues are more quickly coordinated because the nurse is part of the same team."

Deb's and Ann's workdays are filled with visits to consumers and collaborating with providers who deliver support services. In one situation Deb described, she works with multiple providers for one consumer. "The team decided to continue using [the additional provider], even though things are pretty stable right now. We decided to be proactive since things could change very quickly. We are hoping to prevent a crisis."

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Being a part of an interdisciplinary team broadens your viewpoint as a nurse to more than just medical issues because you're working with the social worker on a daily basis."

-- *Deb Kurek, R.N.*

When asked what the interdisciplinary teams see as priorities for the future, Deb feels it is important to continue to strengthen the team concept. "We need to get better at asking consumers the right questions to get at the core of what they expect and need." She would also like to make sure that as their organization develops operational policies and procedures they also maintain flexibility to provide individualized services to consumers.

Building stronger relationships with hospitals and other systems that provide care to consumers is one of Ann's priorities for the future. "Creative Care Options should keep building on what is working. It's nice to stop and reflect on all that we have accomplished but we can't stand still for too long - we have to keep moving ahead!" ◆

Resource Center Prevention Grants

A key function of the Aging and Disability Resource Centers is to help prevent disability, improve functioning and lessen the need for long term care. In order to demonstrate effective prevention practices, available funds for 2000 and 2001 were allocated through a competitive process to our Resource Centers. The Resource Center pilots are documenting outcomes for consumers that will be reported when the projects are completed.

Jackson County: Falls Prevention

Jackson County's falls prevention project is an intergenerational effort which collaborates with the high school, hospital rehabilitative services, Western Dairyland Economic Opportunity Council (EOC), Inc., and the physical therapy department at UW La Crosse. The project has two components. In the first component, 59 adults age 75 and over have been evaluated for balance, muscle strength and walking speed. Home safety evaluations were completed for all 59, and 40 homes are having needed home modifications completed by the Western Dairyland EOC, Inc. High school seniors and healthy older adults have been trained to help the 59 people complete a basic in-home daily exercise program to increase leg strength and overall stability. The second part of the project was a community-based weekly exercise and safety education program for 92 active adults 55 and older living independently in the community. Pre and post-testing for risk of falls is being analyzed for twenty willing participants.

Marathon County: In Home Preventive Health Care

Marathon County's project is a replication of a California project that reduced rates of disability and use of nursing homes. The project includes in-home assessments by a gerontological nurse practitioner for participants 75 and over who reside at home, have no significant physical or cognitive disorder and are not terminally ill. Follow-up visits and assessments are dependent upon assignment to a control or intervention group. The research project is being conducted in collaboration with North Central Health Care and Dr. Mark Sager, UW Madison, Medical School. The Resource Center will strengthen the model by adding telephone monitoring and linkage to Resource Center services. The project is expected to enroll 430 participants over three years.

Milwaukee County: Changing Health Related Behaviors

Milwaukee County Department on Aging, in collaboration with UW Milwaukee, is targeting people aged 60 and over who are African American, Southeast Asian, Hispanic or Native American, and seniors over 70, to assess the effectiveness of three interventions in motivating people to lead healthier lives. The interventions include: a computer-based health risk assessment and internet-based health and fitness education; individual fitness assessments by a trained exercise physiologist and access to equipment and structured workout time; and print information such as pamphlets, booklets and newsletters. A control group that receives no intervention will also be measured. Actual change in physical fitness and feelings about fitness and functionality will be assessed.

Trempealeau County: Nutrition Risk Identification and Intervention

Trempealeau County's project identifies individuals at high or moderate nutritional risk and provides nutrition counseling and personal health planning. In addition, the United Volunteer Caregivers, Inc. is recruiting and training volunteers to provide support services such as friendly visitors, transportation and meal preparation. In addition to evaluating the nutritional health of service recipients, this project will measure the benefits of meaningful volunteer activities for individuals participating in the volunteer program. ◆

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Center for Excellence – Preliminary Planning Begins

During the past year the Department has been planning for a Center for Excellence that would work to enhance the quality of service delivery and interdisciplinary case management in the State's long term care programs. During the summer of 2000 a grant was submitted to the Robert Wood Johnson Foundation (RWJF) to provide seed money for the Center, and last September a team from the Foundation visited Madison to review the grant application and talk with Department staff about Family Care and other long term care programs Wisconsin is developing. The RWJF considers Wisconsin to be very progressive in this area, and fertile ground for research and development of new programs.

The Foundation has offered to fund a nine-month development grant beginning in March 2001 to get the Center for Excellence up and running. Plans call for the Center to be housed within the University of Wisconsin Madison – School of Nursing, and for other partnerships to develop over the first months of the Center's existence. During the planning grant period, the Department will collaborate with the School of Nursing to hire core staff and set up initial contract relationships with other agencies. The Department vision is to create partnerships across many disciplines (social work, physical therapy, etc.) with other University of Wisconsin campuses to foster the development of professional practice standards and to offer training and technical assistance to long term care programs. If the Department meets RWJF expectations, the grant will be expanded to a three-year implementation grant to permanently establish the Center for Excellence as an independent best practice institute and a repository of best practice tools and resources for all long term care programs in Wisconsin.